**Texas Department of Insurance**
*Division of Workers' Compensation*
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

REGENCY HOSPITAL
PO BOX 676164
DALLAS TX 75267

**Respondent Name**

HARTFORD CASUALTY INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 47

**MFDR Date Received**

MARCH 31, 2009

**MFDR Tracking Number**

M4-09-7511-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "It is our understanding that your company has released a payment of $17,500.00 on the above referenced claim. However, it is our position that this claim has still not been reimbursed correctly and that additional benefits of $48,105.76 are due. It is our position that the Texas Board of Workers Compensation stipulates a higher level of payment for this treatment. Per the stop-loss methodology, benefits should be reimbursed at 75% of charges."

**Amount in Dispute:** $48,105.76

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Negotiated rate $700 per day plus vac. However no billing received for vac…provider did not comply w/Rule 133.307(c)(1)(A) for DOS 2/8/08-2/29/08."

**Response Submitted by:**

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 8, 2008 through March 5, 2008 | Inpatient Hospital Services | $48,105.76 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- W3-Additional payment made on appeal/reconsideration. Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided.
- 193-Original payment decision is being maintained. Final action. In accordance with rule 133.250(G): 'A health care provider shall not resubmit a request for reconsideration after the carrier has taken final action on the request.

**Issue**

1. Did the requestor waive the right to medical fee dispute resolution?

**Findings**

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are February 8, 2008 through March 5, 2008. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on March 31, 2009. This date is later than one year after the dates of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

**Conclusion**

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 11/22/2013<br>Date |
|---|---|---|

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.